## STONE IN THE PELVIC PORTION OF THE URETER.

Dr. George E. Brewer presented a man, fifty-two years old, who was referred to the speaker by Dr. Frank H. Whittemore, of New Haven. After a period of ill-health lasting about six months, the patient had an attack of renal colic on the right side. From this he recovered, but six weeks later he had another severe attack, which in passing off left a good deal of soreness persisting for several days. Examination showed a point of decided tenderness about one inch above the external abdominal ring. Palpation in the region of the kidney itself was negative. The patient stated that during his two attacks the pain radiated down into the groin, as in stone in the kidney. The cystoscopic examination was negative, other than the fact that the right ureteral orifice was a little prominent. Examination of the urine was negative. An X-ray examination showed a stone in the pelvic cavity, about half an inch from the spine of the ischium. A diagnosis was made of stone lodged low down in the ureter, and an operation advised. Under ether anæsthesia an eight-inch abdominal incision was made above and parallel with Poupart's ligament, dividing the various layers until the subperitoneal space was reached and the iliac vessels exposed. The ureter was followed downward. It was found moderately thickened below the brim of the pelvis, and, on account of the dense adhesions, was recognized with difficulty. No stone could be detected. An incision was then made in the ureter and a flexible sound introduced and passed downward. This was arrested at the bladder wall. After a prolonged search with the finger, a stone could be felt low down in the ureter. In order to extract it, a second incision was made in the ureter, very low in the pelvis. After removal of the stone, the two incisions in the ureter were carefully closed; the external wound united by layer suture, leaving a cigarette drain leading down behind the peritoneum. The operation, which required an hour and forty-five minutes, was not followed by any reaction, and the patient made an uneventful recovery. There had been no recurrence of his symptoms.

In reply to a question, Dr. Brewer said that, as a rule, in these operations the ureter was lifted with the peritoneum, with which it was in intimate relationship; but in this particular case it was held down by adhesions to the underlying structures. In a case

of ureteral calculus that he reported about a year ago, tenderness was elicited by rectal palpation, but that symptom was entirely absent in this case.

In reply to a question as to what course he would pursue in a case where the X-ray disclosed a calculus in each ureter, Dr. Brewer said that he had such a case under his observation. The patient was a woman, and he advised her to drink large quantities of Poland water. She did so, and under this treatment the pain on one side had disappeared, although it was still very severe on the other. He intended to take another X-ray picture, and if this showed that one of the stones had disappeared, he would advise operating on the ureter that was still occluded.

Dr. Brown said that in some cases the presence of a fair-sized stone or several stones in the ureter interfered very little apparently with the access of urine to the bladder, and any appreciable hydronephrosis was often absent.

The speaker reported the case of a man, seventy years old, who for two years had complained of symptoms pointing to bladder involvement. There were some pyuria, frequent urination, and a bladder that was intolerant of more than one ounce of any irrigating fluid. He suffered some pain and increased irritability if driving, which had been given up on that account. Several surgeons at different times had inferred that these symptoms were due to "cystitis," "vesical calculus," "enlarged prostate."

Dr. Brown's examination satisfied him that neither of the last two existed, and, suspecting ureteral calculus, had several skiagraphs made by two different experts; four of the plates were corroborative, and showed five calculi in the lowermost part of the left ureter, and two at a higher level in the right. An unsatisfactory cystoscopy suggested a tumor referable to the left ureter, and was adjudged a prolapsus of this tube, due to the stones. This inference was supported by the fact that the row of five stones was at a decided angle with the normal direction of the ureter, and that all the stones were much nearer the median line than was the normal position of a ureter mouth.

In another case, where symptoms of ureteral calculus had persisted for fourteen years, there was no hydronephrosis. Here an X-ray-plate showed four calculi in the lower part of the left ureter.

Dr. Brown was asked to catheterize the ureters, and was able

to pass the finest catheter beyond at least one, if not more, of the stones, and he injected a sterile solution. Whether because of this examination or a mere coincidence, the patient nevertheless passed all of the stones from the bladder and handed them to the expectant surgeon when about to operate two days after the ureteral catheterization.

DR. BREWER said it must not be assumed that every shadow disclosed by the X-ray in the region of the ureter was a stone. It had been shown by Leonard that certain small shadows in this region resulted from the presence of phlebolites or calcified lymph glands.

DR. LILIENTHAL said that in a case where the radiograph gave shadows that looked like stones, and the patient gave symptoms pointing to the presence of calculi, it was pretty safe to assume that we had to deal with calculi. In addition to the possible sources of error mentioned by Dr. Brewer, namely, phlebolites and calcified lymph nodes, there was one other that he had seen illustrated in a case of suspected ureteral calculus. The picture gave a shadow that bore a close resemblance to a calculus, but Mr. Caldwell, who took the X-ray, said he was convinced that it was not a stone, but a sesamoid bone, such as sometimes occurred in one of the obturator tendons.

## SOME OBSERVATIONS ON PROSTATIC ABSCESS.

DR. SAMUEL ALEXANDER read a paper with the above title.

DR. BROWN said that, in his experience, prostatic abscess was comparatively rare. He could recall, perhaps, four or five cases, and in two of those rupture had already taken place into the ischiorectal fossa.

DR. LILIENTHAL said that, in opening a prostatic abscess, he could see no advantage in opening the urethra; this, on the contrary, was rather a disadvantage, unless one had to deal with an old chronic abscess, and a fistulous opening into the urethra, where it would be advisable to curette and drain. In an ordinary acute case of prostatic abscess he favored the old-fashioned way of going in directly through the perineum into the capsule of the prostate and draining. This method was rapid and safe, no traumatism was inflicted on the urethra, and it was not necessary to pass any sounds. The speaker said he saw no serious